Worldwide, men have more opportunities, privileges, and power, yet they also have shorter life expectancies than women. Why is this? Why are there stark differences in the burden of disease, quality of life, and length of life amongst men, by race, ethnicity, (dis)ability status, sexual orientation, gender identity, rurality, and national context? Why is this a largely unexplored area of research? *Men’s Health Equity* is the first volume to describe men’s health equity as a field of study that emerged from gaps in and between research on men’s health and health inequities.

This handbook provides a comprehensive review of foundations of the field; summarizes the issues unique to different populations; discusses key frameworks for studying and exploring issues that cut across populations in the United States, Australia, Canada, the United Kingdom, Central America, and South America; and offers strategies for improving the health of key population groups and achieving men’s health equity overall. This book systematically explores the underlying causes of these differences, describes the specific challenges faced by particular groups of men, and offers policy and programmatic strategies to improve the health and well-being of men and pursue men’s health equity. *Men’s Health Equity* will be the first collection to present the state of the science in this field, its progress, its breadth, and its future.

This book is an invaluable resource for scholars, researchers, students, and professionals interested in men’s health equity, men’s health, psychology of men’s health, gender studies, public health, and global health.

**Derek M. Griffith, PhD** is the Founder and Director of the Center for Research on Men’s Health and Professor of Medicine, Health, and Society at Vanderbilt University. His research applies an intersectional approach to explore strategies to eliminate men’s health disparities and improve Black and Latino men’s health in the United States and the health of men across the globe.

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MEN’S HEALTH EQUITY
A Handbook

Edited by Derek M. Griffith, PhD,
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Roland J. Thorpe, Jr., PhD

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Men’s Health Equity: A Handbook is a testament to just how far the men’s health field has developed in the 30 years or so since it began to be identified as a discrete issue.

In the 1990s, men’s health was virtually synonymous with urology, and there was a significant focus on testicular cancer, prostate disease, and erectile dysfunction. Even when the area of interest widened, clinical issues tended to dominate with sexually transmitted infections, suicide, and cardiovascular disease among the topics added to the list.

Women’s health and men’s health were seen as largely separate spheres. Some advocates even felt that they were in some way in competition and sought to highlight the significant differences in research funding between prostate and breast cancers. There was also an assumption that all men were pretty much the same and that they could be effectively engaged through a one-size-fits-all approach, especially if interventions were linked to sport or motor cars.

The state of men’s health work could not now be more different. Advocates are now interested in the widest possible range of health problems affecting men—physical, mental, and social—and not just those that are exclusively male or where the burden on men is greatest.

There is now much more interest in the social determinants of men’s health—the so-called “causes of the causes” of health problems, meaning the factors that lead many men to smoke, drink alcohol at risky levels, or drive dangerously. These underlying factors include racism, homophobia, socioeconomic deprivation, limited educational opportunities, and the constraints of male gender role norms.

Men are no longer seen as a homogeneous group. As this book demonstrates so well, the differences between men are now seen by many in the field as being just as, if not more, relevant than the differences between men and women. A far greater awareness of the need to address “intersectionality” is leading to a greater focus on those groups with the worst outcomes, including gay, bisexual, and transgender men; men from some ethnic minority groups (not least Indigenous populations); men living on low incomes or who are unemployed; homeless men; disabled men; migrant men; and prisoners. Geographic differences in men’s outcomes within individual countries as well as between countries are also being recognized.

Importantly, and increasingly, men are not seen as beings simply trapped within a negative one-dimensional paradigm of masculinity. Yes, men who conform to “traditional” masculine norms do seem more likely to experience poor health. But aspects of masculinity can also be beneficial to men’s health, such as an interest in physical fitness and strength, being goal focused, and providing for a family and being a good father. Masculinity can no longer be viewed as essentially “pathological” or
“toxic,” and an approach to health that builds on men’s strengths is now widely believed to be more effective.

The men’s health field is now much more interdisciplinary, as this book very clearly demonstrates. Clinicians, scientists, public health specialists, psychologists, sociologists, advocates, and policymakers are now engaged much more collaboratively. There is a growing body of high-quality research and evidence on which more effective policy and practice can be based. This evidence is also more widely available through several specialist men’s health journals as well as a range of other publications.

Men’s health and women’s health are viewed as interdependent and interrelational. Better health for one sex translates into better health for the other, most obviously in the field of sexual and reproductive health, but also much more widely. More importantly, it has become clear that both men and women would benefit from an approach to health policy and practice that is gender sensitive and responsive to the needs and sensibilities of both sexes. Men’s health and women’s health cannot any longer be seen as being engaged in some sort of zero-sum game.

The development of national men’s health policies in Australia, Brazil, Iran, and Ireland has helped to highlight the importance of policy work alongside research and practice. It is clear that policy can have a significant catalytic effect on the practices of organizations in the health and related fields. In Ireland, for example, the men’s health policy has led to the development of a wide range of effective community-based health promotion initiatives as well as a men’s health training program for professionals from a wide range of professional backgrounds (including education and social work as well as health).

Men’s health has, in recent years, become a global concern of interest to an increasing number of major organizations, including the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS). Human rights-based approaches to health clearly embrace both sexes, and health economic analyses have highlighted the significant cost of male morbidity and mortality. The UN’s Strategic Development Goals (SDGs) on health, including the target of a one-third reduction in premature mortality by 2030, have a clear relevance to men’s health and have prompted WHO-Europe to develop a men’s health strategy for the 53 countries in its region. WHO-Europe has recognized the importance of working with men to achieve their goal of greater gender equality and to reduce the inequalities in health seen across the region and within countries. Similar action is now required at the global level.

The work of the men’s health “movement,” which includes those organizations working at the international, national, and local levels on men’s health as a generic issue (or on one specific issue, such as prostate cancer), combined with increasing media interest, has created a new public awareness of the physical and emotional health needs of men. There may not have been the radical and political mobilization generated by the women’s health movement, but men’s health advocates are now beginning to achieve at least some of their goals. More men are becoming more actively engaged in their health and more receptive to the changes needed to promote a happier and healthier life.

Global Action on Men’s Health has recently emerged as a nongovernmental organization that is bringing together organizations and individuals active in the field with the aim of raising the need for global action to address the huge disparities in men’s health within countries and between them. Obvious concerns include the 30-year male life expectancy gap between the worst- and best-performing countries and the global pattern of excess male mortality from cancer, suicide, interpersonal violence, cardiovascular disease, road traffic accidents, and occupational hazards. This growing voice is also starting to be heard by politicians and policymakers across the world.

Men’s health is no longer a marginal issue, but it remains far from a mainstream one. No countries have allocated resources that are proportionate to the problems. Most global health organizations do not yet address gender, or they continue to equate gender with women alone. Nonetheless, this is without doubt an exciting and propitious time to be actively involved in men’s
Foreword

health work. The field is rapidly developing in terms of both theory and practice, and this book makes a major contribution that will help all those involved to leap to the next level.

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More than a century after W.E.B. Du Bois called for the elimination of factors that create health disparities (Du Bois & Eaton, 1899), differences in health remain that are not only unnecessary and avoidable but are also considered unfair and unjust (Whitehead, 1991). Although differences in health outcomes between men and women emerged in only the last century (Beltrán-Sánchez, Finch, & Crimmins, 2015), differences in health outcomes between groups distinguished by race, ethnicity, and other socially and politically meaningful factors have a longer history, existing as long as we have had data in the United States and across the globe (Byrd & Clayton, 2000; De Maio, 2014; Krieger, 1987; Woodward & Kawachi, 2000). Although billions of dollars have been spent and an entire “health disparities industry” (Shaw-Ridley & Ridley, 2010) has been born and nurtured, racial and other disparities persist (Bruce, Griffith, & Thorpe, Jr., 2015; Thorpe, Richard, Bowie, LaVeist, & Gaskin, 2013). Despite the recognition that the mortality gap between Blacks and Whites is driven by the poor health of men (Satcher et al., 2005), many are reluctant to consider men’s poor health relative to women’s health as a health “disparity” because non-Hispanic White men are not socially or economically disadvantaged in our society. Braveman (2006) says that “the gender disparity in life expectancy is, albeit an important public health issue, not an appropriate health disparities issue, because in this particular case it is the a priori disadvantaged group—women—who experiences better health” (p. 186). Unfortunately, as a result, adequate resources and attention are not devoted to the health of men who are marginalized by race, ethnicity, immigration status, sexual orientation, and other socially meaningful factors that account for much of the sex difference in mortality globally (Young, 2009; Young, Meryn, & Treadwell, 2008).

The field of men’s health equity has emerged from gaps in knowledge that exist between health inequities and men’s health research. Scholarship on men’s health and scholarship on health inequities have grown largely in parallel, although a need remains to examine where these fields intersect. While the scholarly literature in each area has grown exponentially in recent decades, the science of understanding and improving the health of men who are at the margins of each field—yet lie at the nexus of these literatures—has not kept pace with the development of either field (Griffith, 2018). Improvements in population health and achieving health equity require an accelerated development of an area of specialization that can explicate how and why inequities among men exist and that can present evidence that informs efforts to improve the health of men and reduce inequities among them (Griffith, 2018). This emergent field is that of men’s health equity.
Why the Term “Men’s Health Equity”

The term *men’s health equity* is new. It is an effort to reflect the increasing attention that is being paid to men’s health and gender health equity across the globe by the World Health Organization (WHO, 2018) and others (e.g., Global Action on Men’s Health, Promundo, etc.) (Ragonese, Shand, & Barker, 2018). Historically, systematic differences in health outcomes by gender where men fare worse than women (e.g., life-threatening chronic diseases) (Rieker & Bird, 2005), and systematic differences among men that are rooted in social disadvantage (Griffith, Metzl, & Gunter, 2011) have not fit definitions of health disparities, health inequalities, or health inequities (Braveman, 2014) because these terms have been reserved for differences in health that are due to differences that are thought to be rooted in inequities in underlying social position in society (Braveman, 2003; Carter-Pokras & Baquet, 2002). And yet, while men may be advantaged socially, politically, and economically in most if not all parts of the world, subgroups of men (e.g., particular racial, ethnic, sexual identities) are not. Men’s health outcomes, relative to women who share the same socially meaningful characteristics except gender, and males who share a sex and gender identity but are different by one or more socially meaningful characteristics often have worse health that is rooted in their underlying social position in society. Men’s health equity is an area of research, practice, and policy that seeks to understand and address the needs of these men in ways that are sensitive to and congruent with the socially meaningful identities that have implications for health because their meaning is rooted in inequitable societal structures. The global burden of premature mortality and gender differences in mortality within countries and regions of the world is embodied in these populations of men but little scholarship has focused on their unique challenges or needs and more research, policies, and programs should be informed by a richer understanding of these men.

Why a Handbook on Men’s Health Equity?

Although there are books on men’s health (Broom & Tovey, 2009; Courtenay, 2011; Gough & Robertson, 2009; Lee & Owens, 2002; Robertson, 2007), Latino men’s health (Aguirre-Molina, Borrell, & Vega, 2010), and social determinants of African American men’s health (Treadwell, Xanthos, & Holden, 2012), there is no book dedicated to men’s health equity. The current class of edited volumes tends to focus on specific racial and ethnic groups of men, the psychology of men and masculinities, racial disparities without considering the role of gender, or men’s health without discussing race and ethnicity and the heterogeneity among men along other key dimensions (e.g., sexual orientation, gender identity, [dis]ability status). *Men’s Health Equity* is the first volume to present the state of the science in this field, its progress, its breadth, and its future.

While the editors of the handbook are based in the United States, we are honored to be joined by international scholars in this effort to discuss the complex health issues facing men in Australia, Canada, the United Kingdom, and various countries in Central and South America. Although not representative of the entire world, *Men’s Health Equity* is by far the most comprehensive volume to date on the diversity among men across the globe. Moreover, rather than limit diversity to race, ethnicity, or national context, we are also fortunate to have contributions that discuss critically understudied populations such as rural men, gay and bisexual men, transgender and intersex men, and men with disabilities and functional limitations. This handbook (a) provides a comprehensive review of foundations of the field, (b) summarizes the issues unique to different populations, (c) discusses key frameworks for studying and exploring issues that cut across populations, and (d) offers strategies for improving the health of key population groups and reducing men’s health inequities overall. Beyond simply describing patterns of illness and disease between men and women and among men, those in the field of men’s health equity have sought to use a critical lens to systematically explore the root causes of these patterns, the specific needs of groups of men, and what can be done to improve the health and well-being of groups of men.
Preface

The Organization of Men’s Health Equity

In addition to this preface, we are fortunate to have a foreword by Peter Baker, who is the Director of Global Action on Men’s Health, and Alan White, who is Emeritus Professor of Men’s Health and Founder and Co-director of the Centre for Men’s Health at Leeds Beckett University in Leeds, England to place this volume in the context of the larger field of men’s health. The book is organized in six parts. Part I: Psychosocial and Developmental Foundations of Men’s Health Equity includes the introduction to the book and highlights some of the critical social science roots of men’s health equity by leading scholars who discuss the challenges and benefits of framing men’s health and men’s health disparities in the context of masculinity, manhood, fatherhood, and key phases of life (young adulthood, middle age, older adulthood). Part II: Environmental, Social, and Policy Determinants of Men’s Health Inequities describes three key contextual determinants of men’s health inequities: environments (rural and urban); social determinants (incarceration and domestic violence); and policy (global policies and United States health, public, and social policies). Part III: Health Behaviors and Health Outcomes examines patterns and causes of several leading causes of death among men, including health behaviors; seeking help for mental health concerns; depression, trauma, and suicide in young adult men and across the adult life course of men; diabetes; and cancer. Part IV: Men’s Health Inequities in the United States provides population-specific context to understanding the unique challenges, history, and strengths that men of diverse groups face in the United States. This section includes chapters that provide insight into the patterns and determinants of the health of gay and bisexual men, transgender and intersex men, men with disabilities and functional limitations, and men of each main racial and ethnic group in the United States (Asian men, Black men, European [White] men, Hispanic/Latino men; Native American men; and Pacific Islander and Native Hawaiian men). Part V: Men’s Health Inequities Across the Globe examines the health profiles and the unique determinants of health for men from Australia, Canada, Central America, and South America, including a separate chapter on men’s health in Brazil. Part VI: Final Thoughts and Future Directions includes three contributions: (a) a Life Course Perspective: Implications for Men’s Health Equity by handbook co-editor Roland Thorpe, Associate Professor of Health, Behavior, and Society at Johns Hopkins Bloomberg School of Public Health and Paul Archibald, Assistant Professor of Social Work at Morgan State University; (b) an Afterword by Lisa Bowleg, Professor of Applied Social Psychology at George Washington University; and (c) a Conclusion by the editors, which includes our comments, reflections, recommendations, and wishes for the future of men’s health equity. While we realize this book does not include many health issues (e.g., sexually transmitted infections; heart disease), countries (e.g., Russia), regions of the world (i.e., Africa, Asia, West Indies) that we hoped and initially envisioned, we are delighted that the book is as comprehensive of a treatment of men’s health equity as it is. We hope this handbook helps to educate, inspire, and stimulate new collaborations and research that “center the margins” of populations and health issues that comprise the burgeoning field of men’s health equity.

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Acknowledgment

We would like to thank Erin Bergner for her editorial assistance and review of this preface.

References


Thank you, Christina Chronister from Routledge Publications, for entrusting, supporting, and guiding us throughout this project.

Thanks to all of the contributors to the book. We appreciate how thoughtfully and diligently you prepared your chapters. It is because of your contributions to this seminal work that a greater understanding of men’s health equity has emerged.

We also would like to thank the Chancellor of Vanderbilt University, Nicholas Zeppos, for his support of this book and the Center for Research on Men’s Health at Vanderbilt University.

To Soon-to-be-Doctor Erin Bergner, thank you for the countless hours that you spent reviewing each chapter, brainstorming ways to overcome challenges, editing and formatting, and just investing and believing in this project. This project would not have been completed on time or as seamlessly as it was without your efforts.

Dr. Sharese Terrell Willis of Doc’s Editing Shop, you were truly a Godsend. We are so thankful that we found you on LinkedIn. You paid such critical attention to detail, and you were willing to go beyond our expectations and our contractual obligations to make sure that all aspects of this project met a very high standard of clarity, precision, and uniformity.

This handbook represents the amalgamation of collaborative ideas that we discussed in the not-so-distant past. It is a testament to our collaborative nature and ability to keep our eyes on the prize.

Thank you to the staff and students who worked with us on this and other projects in the Center for Research on Men’s Health at Vanderbilt University and in the Program for Research on Men’s Health in the Hopkins Center for Health Disparities Solutions at Johns Hopkins Bloomberg School of Public Health. We have been blessed to have resources in our respective units to establish a body of research and network of scholars that allowed us to complete this project.

We also would like to thank our families and friends for their unconditional love, inspiration, support, and encouragement.

Last, but of course not least, we thank God for continuing to make a way out of no way and for aligning people and opportunities to guide us into the next frontier of men’s health research, even when we could not see the path. This handbook is a persistent reminder to whom all praises are due and from whom all blessings flow: you.
PART I

Psychosocial and Developmental Foundations of Men’s Health Equity
In most industrialized societies across the globe, men tend to have more opportunities, privileges, and power yet shorter life expectancies than women (Baker et al., 2014; Thorpe, Griffith, Gilbert, Elder, & Bruce, 2016). Although this difference is now seen as normal, it is a relatively recent phenomenon that emerged in the late 1800s (Beltrán-Sánchez, Finch, & Crimmins, 2015) and grew throughout the 20th century and into the new millennium. The Industrial Revolution, the advent of public health as a discipline, advances in medicine, and myriad social, economic, and health policy changes led to dramatic improvements in health across the world. Simultaneously, these technological advances also led to the emergence and persistence of sex differences in life expectancy and premature mortality. The recent emergence of sex differences in life expectancy is a fundamental conundrum underlying calls for the recognition of men’s health as an area of specialization (Meryn & Shabsigh, 2009; Porche, 2007). While there has been little sustained effort by policymakers or practitioners to improve men’s health in the United States or across the globe (Baker et al., 2014), there have been a number of milestones achieved in the effort to raise attention of men’s health as a global issue.

In recent years, there has been a dramatic increase in the number of professional organizations (e.g., the Global Action on Men’s Health, the International Society of Men’s Health, the American Society of Men’s Health, the European Men’s Health Forum), professional journals (e.g., the American Journal of Men’s Health, the International Journal of Men’s Health, the Journal of Men’s Health, the International Journal of Men’s Social and Community Health), and reports (e.g., the American Psychological Association’s Health Disparities in Racial/Ethnic and Sexual Minority Boys and Men, The European Commission’s The State of Men’s Health in Europe, Promundo’s Masculine Norms and Men’s Health: Making the Connections) that has raised awareness of and attention to men’s health. Even in journals that are not focused on men’s health, there have been several special issues on the topic. For example, special issues have been dedicated to men’s health (Crawshaw & Smith, 2009; Gough, 2013; Robertson & White, 2011), biopsychosocial determinants of the health of boys and men (Thorpe, & Halkitis, 2016), diabetes and men’s health issues (Jack, 2004), and patterns and causes of men’s health outcomes (Graham & Gracia, 2012; Treadwell & Ro, 2003; Treadwell, Young, & Rosenberg, 2012). In different ways, these issues have helped to highlight the heterogeneity among determinants of men’s health outcomes, and refine how researchers, practitioners, and policy makers approach efforts to conceptualize and improve men’s health. In addition to these scholarly efforts, important policy initiatives have focused explicitly on improving men’s health in Australia, Brazil, Ireland, and elsewhere. Although men’s health is emerging as a field across the
globe, little of this work systematically examines or addresses the heterogeneity among men. While efforts continue to raise the profile and understanding of men’s health as a field of research, policy, and practice, there also is a need to build an area of study that focuses on men whose determinants and patterns of health may not exactly align with a singular notion of men’s health.

How Do We Define the Field of Men’s Health Equity?

Health equity has been defined as the absence of systematic disparities in health and the determinants of health (Minority Health & Health Disparities Research & Education Act, 2000), and the principle underlying a commitment to eliminate social determinants of health and disparities in health (Braveman, 2014). Braveman (2014) argues that social justice is at the heart of the concept of health equity but it is unclear what data are driving a focus on health equity when men, across the globe, live shorter and often sicker lives than women. Whether measured by rates of premature mortality (World Health Organization, 2014), age standardized death rates in leading causes of death (e.g., cardiovascular diseases, cancers, diabetes, chronic respiratory diseases) (World Health Organization, 2014), life expectancy (National Center for Health Statistics, 2018), or mortality (Bilal & Diez-Roux, 2018), the finding that men fare worse on many health outcomes than women has been a persistent pattern across the world but this difference is not considered a health disparity or inequity.

Braveman (2006) argues that “the gender disparity in life expectancy is, albeit an important public health issue, not an appropriate health disparities issue, because in this particular case it is the a priori disadvantaged group—women—who experiences better health” (p. 186). Recent definitions of health disparities from Healthy People 2020 and others have explicitly included the notion that disparities refer to populations whose health are worse based on some social disadvantage or characteristics historically linked to discrimination (Braveman, 2014). The fundamental problem with this notion is that it does not consider that groups can be advantaged based on one characteristic (e.g., gender) but disadvantaged based on another (e.g., sexual orientation, race, ethnicity, gender identity, educational attainment). This has been a particular problem in garnering attention and resources to focus on the health of men who improve the health of men who account for much of the sex difference in mortality globally (Young, 2009; Young, Meryn, & Treadwell, 2008): men who are advantaged by their sex or gender but marginalized by race, ethnicity, immigration status, sexual orientation, and other socially meaningful factors. Moreover, this highlights how central an intersectional approach is to men’s health equity.

Intersectionality is an analytic and theoretical approach that considers the meaning and consequences of socially defined constructs and that offers new ways of understanding the complex causality of social phenomena; thus, it is a useful framework for examining the complexity of men’s health and men’s health equity (Griffith, 2012). Grounding men’s health equity in an intersectional approach illuminates the heterogeneity among men’s experiences, which are based on their unique, subjective identities and structural positions within systems of inequality and structural impediments. An intersectional approach has been a critical strategy that many scholars (including several contributors to this handbook) have used to demonstrate the complex web of conditions that shape the lives and health of men. These conditions either create opportunities for health equity or health inequities, and the institutional arrangements that create and maintain them (Griffith, Johnson, Ellis, & Schulz, 2010). Thus, the goal of men’s health equity is to shed light on the lives of men that remain invisible when we use the generic terms “men” or “men’s health,” and to move beyond a focus on “what” differences exist between men and women or among men to “why,” “how,” or “under what conditions” such differences (or similarities) illuminate modifiable determinants to improve the health and well-being of men without adversely affecting women’s health (Addis, 2008; Bruce, Griffith, & Thorpe, 2015a; Griffith, 2018). Men’s health equity includes a strong commitment to encouraging and promoting scholarship, policies, and programs to improve
women’s health and achieve gender equity, and highlights the need for each of these areas to consider the realities of the daily lives of women, men, and those who do not readily fit or choose not to be limited by the sex/gender binary.

Men’s health equity is an intersectionality-based health equity lens that highlights that each group of men’s experiences are fundamentally different from that of others, based on their unique identity and structural position within systems of inequality and structural impediments (Griffith, 2018; National Academies of Sciences, Engineering, and Medicine, 2017). Using an intersectional lens to study men’s health requires researchers to recognize and contextualize the ways that race, class, sexual orientation, disability, and other structures and axes of inequity constitute intersecting systems of oppression and yet take on new meaning when combined with biopsychosocial constructs that are applied to men (e.g., sex, gender, masculinities, manhood) (Griffith, 2018).

Men’s health equity is a field of research, practice, and policy that seeks to understand and address the needs of men whose poor health is rooted in their underlying social position in society in ways that are sensitive to and congruent with the socially meaningful identities and structures that have implications for individual-level and population-level solutions to health inequities (Srinivasan & Williams, 2014). Men’s health equity includes two lines of research: (a) a population-specific approach that focuses on identifying, examining, and developing interventions from the unique biopsychosocial factors that affect the health of socially defined populations (Bediako & Griffith, 2007; Jack & Griffith, 2013); and (b) a comparative approach that is useful for identifying and monitoring gaps between men and women and among groups of men that are unnecessary, avoidable, considered unfair and unjust, and yet are modifiable (Carter-Pokras & Baquet, 2002). The National Institute on Minority Health and Health Disparities provides a useful set of definitions of minority health and health disparities that we use to elaborate further on the lines of research that characterize men’s health equity (National Institute on Minority Health and Health Disparities, 2018a).

The population-specific approach to men’s health equity is consistent with the National Institute on Minority Health and Health Disparities definition of minority health. According to the National Institute on Minority Health and Health Disparities, (2018a):

Minority health is the distinctive health characteristics and attributes of racial/ethnic minority groups in the U.S. Minority health research is the scientific investigation of these distinctive health characteristics and attributes of the minority racial and/or ethnic groups. The research questions may focus on protective factors for conditions where outcomes may be better than expected including projects that evaluate mechanisms and interventions to sustain or improve a health advantage. The research questions may also address mechanisms and develop and evaluate interventions to reduce health disparities within a race/ethnic group(s). (Part 2)

As one can see from this definition, the goal of this line of work is to recognize and consider not only unique risk factors that may exacerbate or lead to worse health outcomes, but the goal of this population-specific approach also is to identify protective factors that may be important foundations for building policy and programmatic interventions at any or across biopsychosocial levels and factors. For specific examples, it would be useful to refer to special issues that have been published on minority men’s health (Thorpe, Duru, & Hill, 2015), HIV/AIDS among sexual minority men (Jia, Aliyu, & Huang, 2014; Wolf, Cheng, Kapesa, & Castor, 2013), and African American men’s health (Jack & Griffith, 2013; Thorpe et al., 2015; Thorpe, & Whitfield, 2018; Treadwell, Xanthos, & Holden, 2012; Wade & Rochlen, 2013). In addition to the population-specific approach to men’s health equity, it also is important to consider the comparative approach to men’s health equity.

The comparative approach to men’s health equity is congruent with the National Institute on Minority Health and Health Disparities and Healthy People 2020 definitions of health dis-
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parities. The National Institute on Minority Health and Health Disparities (2018b) argues that health disparities research “is a multidisciplinary field of study devoted to gaining greater scientific knowledge about the influence of health determinants and defining mechanisms that lead to disparities and how this knowledge is translated into interventions to reduce or eliminate adverse health differences” (National Institute on Minority Health and Health Disparities, 2018b, p. NIMHD–9). Also, Healthy People 2020 argues that “Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.” The National Institute on Minority Health and Health Disparities definition of health disparities highlights the multidisciplinary nature of the field of study, the critical need to address determinants of health in addition to health outcomes, and that the goal of this field of study is to develop interventions to reduce or eliminate adverse health differences. Further, as de Melo-Martin and Intemann (2007) so concisely note,

the aim of research on health disparities is not to just accurately describe health differences or determine their cause, but to do so in a way that will be useful to making predictions, preventing greater health disparities, and improving human health.

(p. 218)

In the context of men’s health, there have been special issues on the science of men’s health disparities (Watkins & Griffith, 2013) and social determinants of men’s health disparities (Bruce, Griffith, & Thorpe, 2015a). Although special issues of journals have provided important insights into aspects of men’s health, particularly within groups of men, the science has been limited on addressing how men’s health outcomes are not only shaped by gender but also by other socially meaningful demographic characteristics that represent proxies for understanding stress and other factors that affect health patterns and outcomes (Bruce, Griffith, & Thorpe, 2015b).

Griffith, Metzl, and Gunter (2011) defined men’s health disparities as “research that considers how the individual or population-level health behaviors and health outcomes of men are determined by cultural, environmental and economic factors associated with their socially defined identities and group memberships” (p. 418). In this paper, Griffith and colleagues also offered a research agenda that suggested that men’s health disparities examine three key areas:

(a) how masculinities are related to health; (b) how gender is constructed and embedded in social, economic, and political contexts and institutions; and (c) how culture and subcultures influence how men develop their masculinities and how they respond to health issues.

(p. 418)

More recently, Griffith (2018) defined men’s health disparities as research and practice that “may focus on protective factors for conditions where outcomes may be better than expected including projects that evaluate mechanisms and interventions to sustain or improve a health advantage … The research questions may address mechanisms and develop and evaluate interventions to reduce health disparities among men and between men and women” (Griffith, 2018, p. 1319). Men’s health equity builds from all of this work.

Men’s health equity is a multidisciplinary field of study devoted to gaining greater scientific knowledge about the influence of health determinants and defining mechanisms that lead to inequalities among men and between men and women and about how this knowledge is translated into interventions to reduce or eliminate adverse health differences. The goal of men’s health equity
research and practice is to highlight, inform, and address the distinctive and common determinants of health that shape the health of men whose health outcomes are poorer than those of women and other groups of men whose positions in the social hierarchy are also important for understanding their health (Griffith, 2018).

Men’s health equity is transdisciplinary: research conducted by investigators from different disciplines working jointly to create new conceptual, theoretical, methodological, and translational innovations that integrate and move beyond discipline-specific approaches to address a common problem (Hall et al., 2012; Stokols, 2006). The field of men’s health equity is an effort to move beyond the narrow boundaries and silos of men’s health, specific medical specialties, health inequities (and related synonyms), public health, population health, and various social science disciplines, and to be an umbrella that includes all who are interested in using scientific methods to inform, address, and eliminate avoidable yet unjust differences in health outcomes among men.

Beyond the epidemiologic argument about differences in life expectancy and other outcomes or the moral argument that often underlies the desire to achieve health equity, men’s health equity highlights real economic and social costs of not focusing on differences among men. In their seminal, sobering work, “Economic Burden of Men’s Health Disparities in the United States,” Thorpe, Richard, Bowie, LaVeist, and Gaskin (2013) estimated the potential cost savings from eliminating differences in health disparities among men of color in the United States. Using national data from 2006 to 2009, Thorpe, and colleagues found that the total direct medical care expenditures for African American men equaled $447.6 billion, of which $24.2 billion was for excess healthcare expenditures. With regard to indirect costs to the economy from wages lost because of lower productivity and premature death, African American and Hispanic men were associated with $317.6 and $115 billion, respectively.

Conclusion

The breadth and depth of literature focusing on men’s health equity has grown in recent years; however, there is considerable room for conceptual and empirical expansion and extension. The chapters in this volume represent the state of the science associated with men’s health equity and establish a solid foundation for interdisciplinary discourse. Critical thought and discussion across disciplines can usher in an era of transdisciplinary approaches to men’s health equity needed to address limitations in the current literature. We believe that this handbook is a useful resource for scholars, health practitioners, and policymakers who are seeking a better understanding of factors and mechanisms that contribute to health inequities among men across the globe.

Acknowledgment

We would like to thank Erin Bergner for her editorial assistance and review of this chapter.
REFERENCES

Chapter 1
References


Chapter 2
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1 It is in this sense, in these important links to the larger structural ordering of sets of relations, that gender relational models differ somewhat from other models (such as symbolic interactionism) that focus more on the micro aspects of intersubjective relations.

2 Although Hearn et al. (2012) discuss this in relation to masculinities theorizing in Sweden, at a broad level we see clear similarities in masculinities theorizing across the global north.

3 While being optimistic about these changes in masculinities, researchers of IMT also recognize that such changes are not evenly distributed and that both homohysteria and homophobia continue to exist in both local and national contexts (Anderson & McCormack, 2016).

4 While recognizing this constant state of flux and fluidity within the “masculine bloc,” Demetriou (2001) would not see this as postmodern conceptualizations would: that is, as only being present in discourse and devoid of materiality or material structure.

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References


Johnson, W., Pate, D., & Givens, J. (2010). Big boys don’t cry, black boys don’t feel: The intersection of shame and worry on community violence and the social construction of masculinity among urban African American males—The case of Derrion Albert. In C. Edley, Jr., & J. Ruiz de Velasco (Eds.), *Changing places: How communities will improve the health of boys of color* (pp. 462–492). Berkeley, CA: University of California Press.


References


References


References


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Chapter 11


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Chapter 12


References


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Chapter 13

Notes

1 This group comprised representatives from the Department of Health, the Health Service Executive, the Institute of Public Health in Ireland, the Irish Cancer Society, the Irish Heart Foundation, the Men’s Health Forum in Ireland, and the Men’s Development Network.

2 It is noteworthy that, against a backdrop of men’s “failings” as advocates for their own health, arguably, Ireland’s most important men’s health leader and advocate is a woman.

References


All Ireland Traveller Health Study Team. (2010). *All Ireland Traveller health study*. Dublin, Ireland: School of Public Health, Physiotherapy and Population Science, University College Dublin.


References


References


References
References


References

Chapter 14

Notes

1 By public policy, we refer to governmental policies that affect the whole population. By social policy, we refer to policies that affect the welfare of individuals and families (i.e., child and family support, housing, and income maintenance). By health policy, we refer to governmental policies that pertain to healthcare and public health.

2 MILA is the shortened version of “Orunmila,” the African God of Compassion.

References


References


Georgia Department of Community Health. (n.d.) Medicaid ABCs. Retrieved from https://dch.georgia.gov/medicaid-abc


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References


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References


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References


References


References


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References


References


References


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References


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References


Age-adjusted percentage of civilian, noninstitutionalized popula-


Apesoa-Varano, E. C., Hinton, L., Barker, J. C., & Ünü


References


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References


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Chapter 23

Note

1 I use the terms global North and global South in this chapter to refer to current geopolitical and planetary cartographies of difference and power, even as I recognize that these terms—like the terms developed world and developing world and East and West, all of which are contested—are inadequate to mapping the complexity of global–local power dynamics in any particular situation. For an elaboration of the distinction between global North and global South in the context of contemporary transnational intersex activism, see Ghattas (2013).
References


References


Chapter 24

Note

1 The term *minoritized* depicts “the fact that people often do not see themselves as ‘minority group members,’ but the social structure of their society places them in these subordinate positions” (Ladson-Billings, 2014, p. 448). Ladson-Billings (2014) stresses that instead of “an adjective (i.e., minority), the more accurate term is a passive voice verb (i.e., minoritized)” (p. 448).

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**Chapter 26**

**Notes**

1. SEP refers to the social and economic factors that influence what position(s) individuals and groups hold within the structure of society (Lynch & Kaplan, 2000). SEP is a term that encompasses both social class (referring to social relations of ownership and control over productive assets) and socioeconomic status and should incorporate structural aspects of individuals’ positions in society as well as their subsequent social and environmental exposures, social environment, and behaviors (Muntaner, Eaton, Miech, & O’Campo, 2004).

2. Redlining is described as the practice in which banks would not administer loans to certain residential areas in cities, often populated by Blacks (Conley, 1999; Farley & Frey, 1994). Banks color coded entire cities, and red was the color assigned to the areas in which banks would not offer home loans (Conley, 1999; Massey & Denton, 1993).

3. Coined by President Franklin D. Roosevelt, the New Deal refers to a set of policies initially adopted by the U.S. government between 1933 and 1938. During the administrations of Franklin Roosevelt and Harry Truman, progressive policies such as Social Security, protective labor laws, and the G.I. Bill were adopted (Katznelson, 2005).

4. Residential steering is described as the practice in which real estate agents show home buyers houses that are located in different neighborhoods according to the race of the home buyer (Ondrich, Ross, & Yinger, 2003). Further, this differential showing of homes that are available is likely to be strongly influenced by the racial attitudes and beliefs that real estate agents hold.
References


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References


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References


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### Chapter 30


References


Stannard, D. (1989). *Before the horror: The population of Hawai‘i on the eve of Western contact*. Honolulu, HI: University of Hawai‘i.


References


Chapter 31


References


References


Chapter 32

Notes

1. Each family health unit is composed of at least one doctor (general practitioner or family and community health specialist), one auxiliary (technical degree) nurse, and a maximum of 12 community health agents.

2. In 2015, Brazil reached and surpassed the United Nation’s Millennium Development Goal for infant and child mortality. Despite being promising, the 50% reduction of maternal mortality was still below the goal of reducing it by 75% from 1990 to 2015.

3. As part of the third Fiocruz/IFF and MoH study collaboration, the Prenatal Care for Partners strategy is currently being evaluated among three municipalities in Rio Grande do Norte, São Paulo, and Paraná, Brazil.

References


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References


Instituto de Pesquisa Econômica Aplicada. (2010). *Mulher e trabalho: Avanços e continuidade*. São Paulo, Brazil: Comunicados do IPEA.


Chapter 33


Bowleg, L. (2012a). “Once you’ve blended the cake, you can’t take the parts back to the main ingredients”: Black gay and bisexual men’s descriptions and experiences of intersectionality. *Sex Roles*, 68(11–12), 754–767.
References


References


References


Chapter 34


References


References


References

Prentice, D. A., & Carranza, E. (2002). What women and men should be, shouldn’t be, are allowed to be, and don’t have to be: The contents of prescriptive gender stereotypes. Psychology of Women Quarterly, 26, 269–281.


Chapter 35


References


Afterword


References


Conclusion


